Ontario

Individual Support Agreements for People with Developmental Disabilities

Ministry of Community and Social Services
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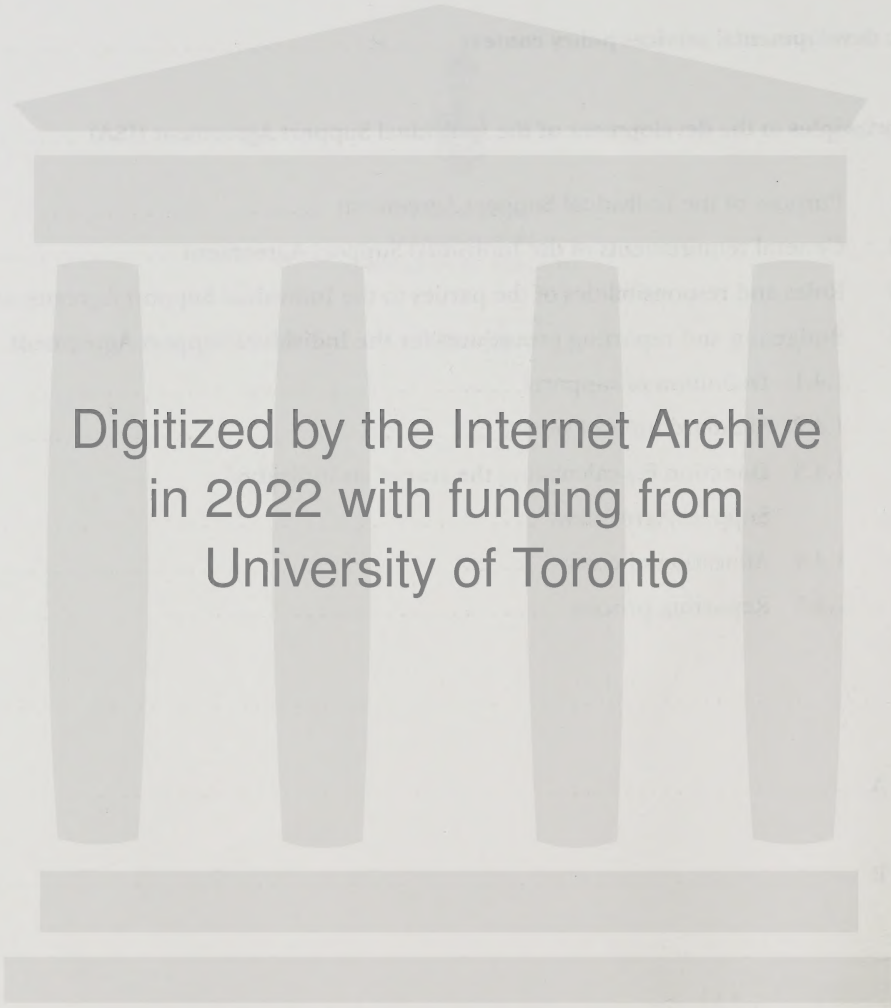

The policy context for the Individual Support Agreement

The *Business Plan* of the Ministry of Community and Social Services (MCSS) commits the Ministry, over the next two years, to reshaping the social services that it funds. The ministry's vision for social services is articulated in its *Business Plan:*

An affordable and effective service system that supports and invests in families and communities to make them responsible and accountable, in adults to make them as independent as possible. A services system in which children are safe and people most in need receive support.

The framework for realigning social services in Ontario is set out in *Making Services Work for People*[1]. To promote change, the ministry has identified four key shifts in direction in the document.

- From government responsibility to shared responsibility.
- From services that respond only to entrenched problems, to services that anticipate, respond earlier and reduce the need for future services.
- From services organized by agency , to services that respond to individuals and families.
- From addressing needs through growth, to doing better within existing resources.

In *Making Services Work for People,* the ministry has identified nine overarching goals for reshaping social services in Ontario.

1. Individuals and families throughout Ontario will have access[2] to a consistent range of core services for children's and developmental services.
2. Those most in need will receive essential supports.[3]
3. Families and individuals will receive supports earlier[4].

1. A new framework for children and people with developmental disabilities, Ministry of Community and Social Services, April 1997
2. Access to a consistent range of core services may not always mean that services are present in each community - especially where services are highly specialized or local population is diverse.
3. Local systems of services must provide mandatory services for children and youth in need of protection and for young offenders. They must also provide other essential supports to ensure individuals are safe from harm.
4. Local systems of services must result in earlier supports, so that individuals and families can rely upon their own strengths, receive supports before problems worsen, remain intact within the family unit and rely less upon services in the future.

4. Families and individuals will have easier access to services.

5. Families and individuals will have services that respond to their needs.

6. Families and individuals will be served by local systems that make the best use of resources.

7. Local systems will have lower administration costs.

8. Families and individuals will receive services that lead to less reliance on government funded services.

9. Families and individuals will receive a coordinated set of services funded by the Ministry of Community and Social Services and other funders when necessary.

In addition, the ministry has developed an Accountability Framework that will direct the development of mechanisms that hold the social services system accountable for results to be achieved. The Framework uses a client outcome[5] approach.

The ministry will develop and use accountability mechanisms that:

- show how the users of the service have benefitted from the service/support; and
- allow assessments of costs and benefits.

A specific developmental services policy context

In developmental services the ministry continues to support the principles of:

- integration into local communities and participation in mainstream community life;
- interdependence (supports that encourage greater independence for the individual and promote relationships with, and support of, families and friends);
- individualization (supports that are focussed on the unique needs of the individual and enhance choice and self direction);
- quality of life; and
- appropriate safeguards.

5. An outcome is the end result of an activity or action rather than the activity itself. It is measurable change as the result of the services and supports received.

Policy development for the developmental services sector is directed to incorporating the following characteristics associated with individualized approaches into the restructured service system:

- person-centred planning process;
- personal empowerment;
- flexibility;
- responsiveness; and
- accountability.

Under current ministry funding policy in developmental services, local area offices contract with service provider organizations to provide one or more specific services or programs. Recently some service providers have begun re-allocating funds from specific programs to more individualized supports to promote organizational change from service oriented to more person centred approaches.

The funding of individualized approaches is the process by which funds are earmarked and spent for a specific person to achieve a specific outcome. The funding of individualized approaches does not necessarily involve a transfer of funds to a person, it does however, mean that funds are spent for the person. In response to and in support of this approach the ministry has undertaken policy work in individualized approaches to planning and funding and an analysis of the impact on the current delivery system.

The Individual Support Agreement provides a mechanism to support service providers in adapting traditional approaches to service delivery and a more flexible approach to supporting a person based on the person's own plan. The Individual Support Agreement has the potential to become the mechanism by which funding could:

- be allocated based on a person's plan and be transferred from one service setting to another (portability);
- be self administered or self directed or brokered by an agent who helps in determining the possibilities for support; or
- be assigned directly from the funder (MCSS) or allocated through negotiation with a service provider from their base budget.

The ministry is promoting the concept of individualized approaches to planning supports and funding for people with developmental disabilities within the ministry's overarching vision and strategic policy directions. Individualized approaches is one strategy among others that will aid in the realization of the vision and is consistent with the strategic directions of restructuring.

The intent of the Individual Support Agreement is to promote individualized approaches to services and supports and enhance accountability.

Guiding principles in the development of the Individual Support Agreement (ISA)

The ISA provides a way to illustrate how the principles named below are present in the provision of services and supports for people. The following principles guided the development of the **Individual Support Agreement.**

Individualization
People will receive appropriate, available services and supports that meet their individual needs.

Choice[6]
People will have the opportunity, wherever appropriate, to choose and adapt the services and supports they receive.

Flexibility
Services, supports and funding can be adapted to meet changing needs.

Effectiveness
The services and supports will meet the identified needs in a timely and responsive manner within available resources.

Accountability
Individuals and service providers will maintain a focus on outcomes and will be accountable for the expenditure of public funds.

1.1 Purpose of the Individual Support Agreement

The purpose of the **Individual Support Agreement** (ISA) is to establish a formal agreement between an individual and/or family and the service provider(s) for services and supports. The services and supports will enable a person, with the support of family and others, to live, work and participate in the community as a valued and contributing citizen.

The Individual Support Agreement sets out the relationship between a service provider's financial allocation and the services and support provided to the individual service user. The Individual Support Agreement outlines, within the context of the developmental services system and available funding, what services and supports are provided and at what cost.

The Individual Support Agreement also provides opportunities for monitoring the accountability of individual service provider organizations in spending public funds in a cost effective, efficient manner that is sensitive to the needs of service users.

6. In some circumstances, people will require supports and safeguards to take greater control of the services they receive.

The agreement will assist families and individuals in receiving the most appropriate available level of services/supports to meet their needs. Where they need more than one kind of service/support, the agreement will ensure that they receive the services/supports in the right sequence, so that services work together to support the best possible outcomes.

The intent of the Individual Support Agreement is to promote and facilitate individualized services and supports and accountability. Service providers will:

- work with individuals and families to identify expected outcomes of services and supports;
- work together to ensure that individuals and families receive a coordinated set of services and supports in the right sequence, so that the best possible outcomes are achieved; and
- work through local restructuring initiatives, to put in place effective mechanisms to ensure they can carry out agreements.

The **Individual Support Agreement** will:

- ensure that individuals and families are integral parties to the agreement for services and supports;
- ensure that individual, family and community responsibility is not eroded;
- support and enhance the individual's informal support system;
- verify that potential resources and supports have been considered in the development of the agreement;
- ensure the services and supports match the needs identified through the individualized planning process and a levels of support assessment when it becomes available when it becomes available;
- ensure the cost effectiveness of the services and supports is consistent with comparable local and provincial expenditures;
- ensure ongoing monitoring and review of contracted services and supports to individuals for their effectiveness, efficiency and cost effectiveness; and
- ensure that the importance of individuals' and families' perception of the quality of services and supports is recognized.

The Individual Support Agreement will not:

- be a substitute for a life plan[7];
- provide entitlement[8] to MCSS funded services and supports; or
- ensure access to services and supports of other funders[9].

7. Characteristics of a life plan, Appendix A.
8. Entitlement is set in legislation as a mandatory service or benefit based on an eligibility determination.
9. The ministry encourages the inclusion of other funders in the development of the Individual Support Agreement.

1.2 General requirements of the Individual Support Agreement

a. Applicability

Each individual and family in receipt of MCSS-funded developmental services and supports must have a completed Individual Support Agreement (ISA).

b. Authority

The requirements for the Individual Support Agreement are considered provincial policy. Information is collected under the legal authority of the *Developmental Services Act*, R.S.O., 1990, c.D., 11, the *Homes for Retarded Persons Act*, R.S.O. 1990, c.H. 11 and the *Child and Family Services Act*, R.S.O., 1990 for administering the Ontario Government's programs. Local application is to be consistent with the legislation and stated policy.

c. Confidentiality

Individuals have a right to privacy and the confidential treatment of their life plans, Individual Support Agreement and all other information about their personal lives.

Service providers must have policies and procedures related to the creation, maintenance, disclosure and destruction of records.

Service providers should:

- ensure confidentiality with respect to individuals' information is maintained and the individuals' right to privacy is considered in any sharing of information;
- make every effort to ensure information collected and shared is both accurate and complete;
- ensure the individual provides **informed consent**[10] to the release of the information;
- ensure that consent is specific to something - for example, consent to release information received from an individual on admission to service/support does not necessarily mean that there is consent to release information gathered throughout the period the individual receives the services/supports; and
- release only the information the service provider needs to know to perform the duties/functions required.

10. To meet the requirements for informed consent, individuals who agree to disclose information must do so voluntarily, knowingly and willingly.

d. Developing an Individual Support Agreement

1. A single ISA is completed for the individual receiving MCSS-funded services and supports, exclusive of the number of service providers.

2. A general service/person centred /life plan must be available, upon request, jointly developed and approved by the individual or family. The Individual Support Agreement is completed based on some of the information provided in the plan.

3. In those situations where the individual does not have family or friends independent of the service system to assist him or her, consideration must be given to identifying an external advocate to participate in the life plan and ISA processes.

4. A person is identified, and agreed to by the individual and/or family, as having primary responsibility for coordination of the services and supports; this could be a family member.

5. If the individual receives residential supports, decide the total hours of support required and record using the Ministry of Community and Social Services' levels of support tool, when it becomes available.

6. If the needs of the individual change significantly during the term of the agreement, the person with responsibility for coordinating will review the situation with the parties to the agreement, and jointly decide what revisions are required to the agreement and then will amend the ISA appropriately.

7. The term of any Individual Support Agreement will be twelve months but the term may be for a shorter period of time where appropriate and agreed to by the parties to the agreement.

e. Reporting on service/supports delivered and actual expenditures

On completion of the term of the ISA and before completion of a new ISA, service providers will make available to all parties to the original ISA the following information:

(i) the actual amount of service/support provided to the individual; and

(ii) the actual cost for the delivery of the service/support provided to the individual.

f. Compliance

Random auditing of Individual Support Agreements by staff in the local MCSS offices, within existing audit processes, will determine compliance with provincial legislation and policy.

g. Funding policy and processes

Funding of Individual Support Agreements will occur within the context of the ministry's current funding policy framework; allocation of funds will continue to base funded, transfer payment service providers through a negotiated Consolidated Service Contract. Use of allocated funds must continue to be consistent with stated government and ministry priorities and ministry policy directions.

- Service providers will accommodate changes in Individual Support Agreements to meet the needs of their service users within existing resources;

- Program administration costs may be assigned to Individual Support Agreements; central administration costs[11] may not.

- A new **Services/Supports Schedule**[12] for developmental services will be added to the Consolidated Service Contract in the future. Staff in local MCSS offices will negotiate the Service/Support Schedule based on the number of ISAs that position the existing resources against the needs of no fewer than the existing service user population.

- Annually, service providers will provide the following information to the local MCSS office:

  (i) total number of ISAs;

  (ii) actual aggregated amount of service/support provided by support type; and

  (iii) actual aggregated cost for the delivery of services/supports provided through the completion of an **Annual Status Report**[13].

1.3 Roles and responsibilities of the parties to the Individual Support Agreement

In addition to understanding what the Individual Support Agreement is and how the process works, all those who participate in the process need to know the expectations of them. They should know their rights and responsibilities in providing or receiving services and supports through the ISA.

Individual/family

The individual and/or family has a primary role in planning services. The individual and/or the family is responsible for:

1. developing, agreeing to and signing the Individual Support Agreement (ISA);

11. Central administration costs are those costs associated with governing and operating an organization. It does not include those administrative functions that directly support service to the individual. Reference definitions in MCSS budget package.

12. Implementation is planned for the 1998/99 fiscal year.

13. Implementation is planned for 1998/99 fiscal year.

2. taking responsibility for the provision of informal supports where agreed to in the ISA;

3. participating in monitoring and evaluating the quality of service/supports;

4. verifying the quantity of service/supports delivered; and

5. informing the service coordinator of any change in circumstances that affects needs or priorities.

Service Provider/s

The service provider/s is responsible for:

1. agreeing to the provision of services/supports and signing the Individual Support Agreement (ISA);

2. organizing the provision of services/supports determined and agreed to in the ISA;

3. participating in monitoring and evaluating the quality of services/supports;

4. maintaining all records including descriptions of the services/supports and statements of the dates and hours in which services/supports were provided;

5. making available to the Ministry of Community and Social Services, upon request, all such records;

6. reporting on service/supports delivered and actual expenditures; and

7. ensuring that established policies and procedures for confidentiality are in place for the collection, use and transfer of information related to the individual and/or family and the ISA.

Service Coordinator

The individual with responsibility for coordinating the Individual Support Agreement is responsible for:

1. having a comprehensive knowledge of the range of services/supports available in the local system of services;

2. ensuring the appropriate people are involved in the ISA process;

3. consulting and working with the individual and/or family to decide the priority of needs to be met;

4. verifying that all potential resources and supports have been considered in the development of the agreement;

5. coordinating access to services/supports and the timetable for delivery of services/supports;

6. helping communication with and between funded service providers, informal family and community supports and other funders to reduce duplication, clarify responsibility and ensure accountability;

7. ensuring that established procedures for confidentiality are in place for all service providers in collection, use and transfer of information related to the individual and/or family and the ISA;

8. monitoring the status of the ISA to ensure coordination, continuity and appropriateness of services/supports; and

9. participating in monitoring and evaluating the quality of services/supports.

Ministry of Community and Social Services

The Ministry of Community and Social Services is responsible for:

1. monitoring compliance with provincial policy through regular auditing of Individual Support Agreements; and

2. monitoring and evaluating the quality of the system of services and supports.

> The Ministry reserves the right to conduct random audits of service providers to ensure appropriate processes are in place related to the development of the Individual Support Agreement and associated services/supports and costs.

1.4 Budgeting and reporting procedures for the Individual Support Agreement

The Individual Support Agreement sets out the relationship between a service provider's financial allocation and the services and support provided to the individual service user. The Individual Support Agreement outlines, within the context of the developmental services system and available funding, what services and supports are provided and at what cost. Funding of Individual Support Agreements will occur within the ministry's current funding policy framework; allocation of funds will continue to base funded, transfer payment service providers through a negotiated Consolidated Service Contract. Use of allocated funds must continue to be consistent with stated government and ministry priorities and ministry policy directions. Service provider organizations must establish unit costs of service by support type, within their organization, and assign costs to individual support agreements based on the total units of service received.

1.4.1 Definition of supports[14]

A. Respite supports

The objective of Respite Supports is to provide relief for primary caregivers. Respite supports fall under two categories:

- *in-home respite* is typically provided by trained individuals who come into the home on an on-call or regular basis; and

- *out of home respite* may be provided on a day, overnight or extended basis in a number of settings outside the person's home (e.g. beds within a service provider operated home or host family home).

14. Definitions do not at this time correspond with Ministry Chart of Accounts or data collection requirements.

Key components:

- a personal plan is in place for the individual;
- support is short term for the purpose of providing a break for the primary caregivers;
- any rate charged to the primary caregiver is negotiated between the MCSS funded service provider organization and the caregiver; and
- limits on the number of respite hours or days provided to the primary caregiver is negotiated between the MCSS funded service provider organization and the caregiver.

These supports respond to statements such as:

- We want to have our son continue to live with us but we need a break.
- We want to keep our adult daughter living with us and need some assistance.

B. Community living supports

Community living supports are residential supports provided in a range of settings. The objective of Community Living Supports is to assist people to live in the home of their choice. Community living supports fall under three categories:

- *Individual living supports* are provided to a person to help him\her live independently. Typically the support is not provided for more than two people living in the same setting.

Key components:

- a personal plan is in place;
- a person is living on their own or with a friend and requires some supports;
- supports are determined on an individual basis, with a focus on independence;
- 24-hour support is not provided, however, it can be made available on an emergency or limited basis; and
- the home is usually rented or owned by the person, family or landlord.

- *Group living supports* are provided to a person living in a shared arrangement, with other people who also require supports. The number of people living together typically ranges from three to six.

  Key components:

  - a personal plan is in place;
  - support up to 24 hours is available when required and there is a staffing model focus;
  - the level of support is based on a person's need, with shared staffing for certain areas of support, where required; and
  - the home can be rented or owned by the person(s), family or by the service provider organization.

- *Associate living supports* are provided to a person living in a host family situation. Typically no more than two people requiring supports live with a family.

Key components:
- a personal plan is in place
- the level of support is based on the person's needs;
- support up to 24 hours is available, where required; and
- the home is rented or owned by the host family.

These supports respond to statements such as:

- I am now an adult and want to live in my own home.
- I want to live more independently.

C. Community participation supports

The objective of community participation supports is to facilitate access to employment and other community activities. Community Participation Supports are divided into three categories:
- *Employment supports,*
- *Vocational alternative supports,* and
- *Community access supports.*

- Employment supports for people with disabilities are:
  - supports to competitive employment for people with disabilities; and
  - workshops for people with physical disabilities.
- Vocational alternative supports are designed to support people in participating in settings outside of the competitive wage/labour marketplace i.e. ARC Industries.
- Community access/non-vocational supports are designed to assist people to participate in the community and develop personal competence to access community services/supports e.g., volunteering, life skills.

These supports respond to statements such as:

- I need to learn some job skills so that I can work.
- I need help to get a job and keep it.
- I would like to volunteer at my local seniors centre.

D. Specialized community supports

The objective of specialized community supports is to provide customized supports which are needed to assist a person in his/her environment or to enhance access to community. Supports such as behaviour intervention, infant development, service co-ordination and adult protective services are examples of specialized supports. These supports should not duplicate services available through the generic service system.

Key components:
- a personal plan is in place; and
- typically these are short term supports which assist in community living and community participation.

These supports respond to statements such as:

- I need help getting services and supports.
- I need help in learning how to budget.
- We don't know how to deal with our son's behaviour and need help.

1.4.2 Standard units of service

The service provider organization must use the following standard units of service identified for each support type when calculating and reporting the amount of service and the cost of service in the completion of the Individual Support Agreement.

		Data Collected In (SPO reports in)	Unit Cost Calculation
A.	**Respite Supports**		
	- in-home respite	hours	hours
	- out of home respite	days	days
B.	**Community Living Supports**		
	- individual living supports	hours	hours
	- group living supports	days	days
	- associate living supports	days	days
C.	**Community Participation Supports**	hours	hours
D.	**Specialized Community Supports**	hours	hours

The Developmental Services Branch maintains information on the use of developmental services, which includes data on the types of supports used, number of users and cost of providing the supports. In order to ensure the integrity of the information, it is essential that service provider organizations maintain accurate records and report accurate information in the Individual Support Agreement. Service data will be aggregated at the community and at the provincial level and shared with service providers, local planning groups and other interested groups for planning purposes.

1.4.3 Direction for calculating the cost of an Individual Support Agreement

1. Determine the number of units of service a person will receive of each support type.

   Note: The amounts of service will be identified as part of the personal planning process. The unit of service is taken from the standard unit(s) identified for each support type.

2. Identify the unit cost of service for the support type.

3. Add the unit cost of program administration for the support type.

4. Subtract any unit cost of expenditure recoveries including, but not limited to, parental contributions, Ontario Disability Support Program.

5. Total costs = number of units of service x (unit cost of service + unit cost of program administration) - (number of units of service x unit cost of expenditure recoveries).

Example

Respite Supports - in-home respite

Number of units of service	100 hours
Unit cost of service	$12.87/hour
Unit cost of program administration	$ 5.72/hour
Recoveries - parental contribution	$ 1.27/hour

Total Cost = 100 x ($12.87 + $5.72) - (100 x $1.27)
= 100 x ($18.59) - ($127.00)
= $1,732.00

Note: a. Costs related to supervision of direct care staff should be included in the hourly or daily rate set for the cost of a unit of program administration.

b. The unit cost should be based on the MCSS approved budget and should be calculated as an average cost of providing supports.

1.4.4 Allocation of costs

The allocation method for costing the Individual Support Agreement budgets must remain consistent throughout the year for comparison. Any modifications during the year must be discussed with the ministry.

1.4.5 Reporting process

The ministry will provide agencies with an Annual Status Report that will include a summary of Individual Support Agreements. It is to be completed and filed with the local ministry area office, no later than three months immediately following the fiscal year end.

Summary

The introduction of the Individual Support Agreement is the first phase of a phased-in approach to enhancing accountability and individualized approaches to services and supports in the developmental services sector. Individual Support Agreements will result in services and supports that are more responsive to the needs of individuals and families and more accountable for the use of public resources. Individual Support Agreements will be phased in to the developmental services system beginning in the fiscal year 1997-98.

Each service provider will need to assess their own organization to determine the most effective methods for introducing and managing any organizational change required by the introduction of the Individual Support Agreement. The ministry expects that service providers will accommodate and implement the changes associated with the transition to Individual Support Agreements within their current funding allocation.

Appendix A

Individualized Planning

Over the past few years, there has been growing recognition of the need for more effective individualized planning for people with developmental disabilities. Developing a plan with an individual with a developmental disability is more than attending a meeting to write a few outcomes from services and supports. Much preparation and investment of knowledge and time has to be made by all who have been identified to participate. The following is intended to assist participants in the individualized planning process, including the people who are the focus of the planning and their families, friends and advocates, service providers and those who provide coordination of services and supports.

Background

Planning is something that is continuous and lifelong. Individualized planning can involve setting someone's schedule for the next day or charting a course for the next few years.

Significant efforts have been made in recent years to re-shape the process known as Life Planning or General Service Planning in order to connect with individuals in a more naturally supportive manner. This shift has served to look beyond the limits of the service system and personalize the process considerably. The evolution of planning principles and practices in developmental services has seen less emphasis placed on eligibility criteria such as diagnosis and functioning level, and more emphasis placed on self determination and community inclusion as factors in determining service delivery. Consequently, the general frameworks for planning that now exist promote involvement of the family and significant others in the process. Real life choices, intimate relationships, dignity and respect, work and community participation have become central considerations in the efforts to serve individuals and their families.

Life Planning has allowed for a better understanding and appreciation of the individual as a contributing member of the community. The person is seen more as having a history, a lifestyle and a future that goes beyond the services provided.

The successful development of individualized planning has helped redefine the relationship between the service user and service provider. A number of specific improvements have taken place.

- First and foremost, expectations have been re-established with the individual, his/her family and friends, and the community at large with respect to their contributions to the support situation.

- Second, service providers have generally become much more focussed on the individual and have created innovative supports consistent with goals and interests.

- Third, service providers have developed a certain capacity to define the costs of their various services and supports based on individuals and not just programs.

Individualized Planning Principles

Planning principles represent the value base of practice. One real measure of a set of principles is how easily they can be generalized to other populations. It can be argued that the principles of planning stated below, while applied in the context of planning with individuals with developmental disabilities, are equally relevant to non disabled individuals.

- The individual should be central to the process at each and every step. The process should include the individual and move forward in a fashion that respects his/her interests and concerns.

- The individual's family are major stakeholders in the process. Regardless of their level of involvement, they should be respected as key participants in the planning process. In situations where there is no family participation for whatever reason, efforts should be made to involve an outside advocate.

- The planning process should be as accommodating as possible to the individual and his/her family in terms of pacing, timing and location of meetings and participants.

- Planning should be creative and flexible in order to be individualized.

- The process should be open to participation from different people with various perspectives. The common denominator is the commitment each has for the welfare of the individual.

- Plans and planning should change as the individual changes.

- The written plan as a document has limited importance. Its true value lies in the process it represents.

- It is the planning process, not the service user that should be managed.

Putting Principles into Practice

The process of individualized planning is most often a simple, straightforward exercise that continues through a person's lifetime. While no prescription can be written to detail the planning process, certain rules of practice should be adhered to in all cases.

- Identify the major stakeholders and work through the process in a manner that is as respectful and responsive to the individual's situation as possible.

- It should be accepted that the most meaningful planning happens in a place of the individual or their family's choosing.

- Allow the process to flow from the general to the specific that allows particular short term goals to make sense within a broader picture.

- Be prepared to compromise on some of the details and practices and procedures which exist within a framework of principles. The principles themselves can only tolerate compromise if certain safeguards are put in place to avoid significant negative impacts.

- The process of connecting with the service user and family is more important than the paper that exists to reflect that process.

- The plan itself should be simple and straightforward. It should not be made more complicated than is necessary. More writing and sophisticated language won't result in additional funding.

- Support individuals and families to plan with the same freedom and opportunity we all have. Create a process in which anyone would be proud to participate.

Note : It is not the ministry's intent to specify what must go into a plan, but rather the characteristics of a plan which should be considered.

Individual Support Agreements

The same principles and practices of individualized planning that have evolved are central to the creation of an Individual Support Agreement. The service user, the family and other major stakeholders should be active and respected participants in the development of the ISA. With their involvement the agreement defines and clarifies the individual's and organization/s role and responsibilities in achieving a desired outcome or set of outcomes.

Appendix B

Developmental Services Accountability Initiative

The Individual Support Agreement is part of the application of an overall Ministry of Community and Social Services Accountability Initiative in the developmental services system. The Initiative is designed to promote the following characteristics in an accountable developmental services system.

- The emphasis is on potential and outcomes are more individually defined.
- Service users/families/friends are integral to decision-making.
- Responsibility for supporting community inclusion for the person with a developmental disability exists at many levels: the person, family, friends and natural community, generic community resources, and lastly specialized services and supports.
- Creative flexible management of available resources to support individuals is achieved by setting priorities, ensuring the most efficient use of resources and integrating services and supports.
- Resources are directed to prevention of increased need in individuals.
- Services/supports are developed and redeveloped to respond to local needs and priorities within the scope of available resources.

Ontario Ministry of Community and Social Services

Individual Support Agreement/

This information is collected under the legal authority of the *Developmental Services Act*, R.S.O. 1990, c.D. 11, the *Home for Retarded Persons Act*, R.S.O. 1990, c.H.11, the *Child and Family Services Act*, R.S.O. 1990 c.D.11, *Vocational Rehabilitation Services Act*, R.S.O. 1990 c.V.5 or its successor and the *Ministry of Community and Social Services Act*, R.S.O. 1990 c.M.20, for the purpose of administering the Ontario Government's programs for the people with developmental disabilities. For further information contact your nearest Community and Social Services Area Office.

Please type or print in ink. This form must be signed by all parties to the Agreement.

Section A : Service User Profile

Surname | **First Name** | **Initials** | **Gender** ☐ Male ☐ Female | **Date of Birth** dd mm yy

Address (House or Apt. Number, Street Name) | **Phone Number** Home Area Code

(City/Town) | (Postal Code) | Work Area Code

Name of Family/Guardian/Emergency Contact

Address (House or Apt. Number, Street Name) | **Phone Number** Home Area Code

(City/Town) | (Postal Code) | Work Area Code

If Community Living supports are provided, please complete the following:

a. Which support type is the individual receiving? ☐ Group Living ☐ Individual Living ☐ Associate Living

b. Address at which the support is being provided: _____

c. Date the individual began receiving the support: dd mm yy

d. Date of last Level of Support (LOS) Assessment: dd mm yy

e. Total hours of support required as per LOS Form B (Form #1063) : _____

Individual Life Plan attached? ☐ Yes ☐ No

a. If "No", date by which a plan will be in place: dd mm yy

b. MCSS subsidized units of support in the plan represent an: ☐ Increase ☐ Decrease (over previous period)

c. Total Fiscal Commitment of Agreement (as per section D) $ _____

d. Percentage of costs attributed to MCSS (as per Section D)? _____ %

e. Has a personal outcomes assessment such as Quality of Life been completed? ☐ Yes ☐ No

Section B: Service Provider Profile

Name of Service Provider

Address (House or Apt. Number, Street Name)

(City/Town)

(Postal Code)

Phone Number
Home
Area Code

Work
Area Code

Primary Contact

Address (House or Apt. Number, Street Name)

(City/Town)

(Postal Code)

Phone Number
Home
Area Code

Work
Area Code

Name of Service Provider

Address (House or Apt. Number, Street Name)

(City/Town)

(Postal Code)

Phone Number
Home
Area Code

Work
Area Code

Primary Contact

Address (House or Apt. Number, Street Name)

(City/Town)

(Postal Code)

Phone Number
Home
Area Code

Work
Area Code

Name of Service Provider

Address (House or Apt. Number, Street Name)

(City/Town)

(Postal Code)

Phone Number
Home
Area Code

Work
Area Code

Primary Contact

Address (House or Apt. Number, Street Name)

(City/Town)

(Postal Code)

Phone Number
Home
Area Code

Work
Area Code

Section C: Person or Agency Providing Service Coordination

Name of Person or Agency

Address (House or Apt. Number, Street Name)

(City/Town)

(Postal Code)

Phone Number
Home
Area Code

Work
Area Code

Section D: Budget Summary (taken from Section E: Individual Budget Summary)

(i) Service Provider	Fiscal Commitment $	Fiscal Commitment %
1.		
2.		
3.		
(ii) Cost Recoveries		
- Personal/Parental Contribution		
- Other		
(iii) Other Funding		
- MCSS		
- Non-MCSS		
Total Fiscal Commitment for the Term of the Agreement		

Certification

I/We have supplied the information in this form to the best of my/our knowledge and belief.

Term of the Agreement: From: _____ To: _____

Parties to this Agreement

Print and Sign your name	Date

Section E: Individual Budget Summary

Community Inclusion Supports	A Total Units of Service (hrs/days)	B Cost per Unit of Services	C Cost per Unit of Program Admin.	D Total Cost (B+C)xA)	E Cost Recovery	F Total MCSS Cost (D-E)	G Service Provider Name
Respite Support							
a. In-Home Respite							
b. Out-of-Home Respite							
Community Living Supports							
a. Individual Living							
b. Group Living							
c. Associate Living							
Community Participation Support							
a. Vocational Alternatives							
b. Community Access/Non-vocational supports							
Specialized Community Supports							
a. Service Coordination/ Case Management							
b. Behaviour Management/ Intervention							
c. Infant Development							
d. Speech and Language							
e. Assessment & Counselling includes psychological services							
f. Adult Protective/Family Support Services							
g. Other (specify, e.g. social work, physio/occupational therapy, music therapy, health services)							
Total							

Other MCSS Funding

	$	Comments
- Handicapped Children's Benefit (HCB)		
- Ontario Disability Support Plan (ODSP)		
- Special Services at Home (SSAH)		
- Employment Supports (See Manual)		

Other Resources (What other sources of support or funding are currently available to help meet the needs identified in the Individuals Life Plan?)

Non MCSS Funding		
- Ministry of Health		
- Municipal		
- Other (specify)		

Non Paid Supports	
- Volunteer program	
- Literacy programs	
- Parental support (in kind)	

Section F: Outcomes

Describe what outcomes are expected to be achieved during the term of the agreement, from the above-listed supports.

Supports	Outcomes

Section G: Support Agreement Monitoring

1. Has the level of MCSS-funded support in the current agreement increased/decreased over the previous agreement? Please specify.

2. What other sources of service or funding have been pursued to meet the needs identified in the life plan? Please specify.

3. Does the current agreement reflect an increase/decrease in the use of **Specialized Community Support**? Please specify.

4. Does the current agreement reflect an increase/decrease in the use of non-MCSS-funded community supports?

5. What barriers, if any, were experienced in meeting the outcomes identified in the previous agreement?

6. Overall, how satisfied is the individual/family/advocate with supports received?